Flagler Family Medicine, P.A.

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

CONDITION	YOU	LIST RELATIVE	CONDITION	YOU	LIST RELATIVE
DIABETES			ANEMIA		
HIGH BLOOD PRESSURE			LEUKEMIA		
STROKE			SICKLE CELL		
HEART ATTACK			BLEEDING PROBLEMS		
ASTHMA			STOMACH ULCER		
MIGRAINE HEADACHES			GALLSTONES		
CANCER			SEIZURES		
EMPHYSEMA			TUBERCULOSIS		
KIDNEY PROBLEMS			ALCOHOLISM		
ARTHRITIS			SUICIDE		
GLAUCOMA / EYE PROBLEMS			DEPRESSION		
SKIN RASH			MENTAL ILLNESS		
OTHER			OTHER		

OPERATIONS / SURGERIES: ____

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Last Colonoscopy:_________________________

OTHER HOSPITALIZATIONS: ____

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BLOOD TRANSFUSIONS: ____

MEDICATIONS: ______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Last Pneumonia Vaccine(Pneumovax or Prevnar):______________________________

Last Flu Vaccine:______________________________

ALLERGIES: (Any reaction to any medication of any kind?) ______________________________

OCCUPATION / WORK HISTORY: ____

Any exposure to pesticides, chemicals, or other hazards? YES ______ NO ______

If yes, What kind? ____

Family / Household: (Who lives at home with you?)______________________________

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HABITS: Cigarettes: _________ PPD ____ X ________ years Quit in _____________ (year)

Other Tobacco Products? ______________________ Alcohol ______________________

Drug Use ______________________ Caffeine (coffee/colas)______________________

Seat Belt Use: Yes: _____ No _____ Exercise: ______________________

FOR WOMEN ONLY

Age of first menstrual period ______________________ How many days between periods? __________________

How many days does it last? ______________________ Is bleeding heavy or light? ______________________

Date of last menstrual period ______________________ Was it normal? ______________________

If menstrual periods have stopped, have you had any bleeding since? ______________________

Any Vaginal Discharge? Yes ________ No ________

Method of Preventing Pregnancy ____

Pregnancies ______________________ Births _______________ Abortions/Miscarriages ______________________

Last Mammogram:______________________Last Bone Density:______________________

Last Pap Smear: ______________________

Any other concerns? ____

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Name: ______________________________

Social Security: ______________________________

Birth Date: ______________________________